

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/29/03.

I. DISPUTE

Whether there should be reimbursement for CPT codes 90806, 90889 (date of service 8/5/03), 90806, 90889 (date of service 8/12/03), and 90901 (billed 60 minutes), 90901 –51 (billed 60 minutes), 90889 (date of service 9/16/03).

II. RATIONALE

The services in dispute were denied as, “F053 – This procedure code or National Drug Code is not valid for this date of service,” and “X160 – This charge is denied because an invalid procedure code was submitted.”

The Requestor states, in their letter dated 12/15/03, “Reimbursement for services is dependent on the accuracy of the coding and documentation. All participants shall be responsible for correctly applying the ground rules contained within the Medical Fee Guideline, and the rules contained within the CPT/HCPCS, the ICD9-CM coding system, and the global surgery coding guidelines.” EOB’s were provided for dates of service 8/5/03 and 8/12/03. The Requestor states, in their letter dated 12/22/03, “We sent a Request for Reconsideration to AIG Claims.” There were no EOB’s for date of service 9/16/03. Rule 133.307 (e)(2)(B) states in part, “...if no EOB received, convincing evidence of carrier receipt of the provider request for an EOB.” Requestor enclosed a copy of the certified mail receipt, addressed to AIG Claims.

The Carrier’s position states, “The codes billed are not supported by the diagnosis codes on the HCFA-1500s.” Rule 133.307 (j)(2) states, “The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review.”

Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, “For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section.” To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies. The conversion factor to be used for determining reimbursement in the Texas Workers’ Compensation system is the effective conversion factor adopted by Centers for Medicare and Medicaid Services multiplied by 125%.”

Per Commission Rule 134.202 and the Medicare Fee Guideline, partial reimbursement is recommended. The following table will depict reimbursement methodology:

Date of Service	CPT Code	Medicare Allowable	Conversion Factor	Maximum Allowable Reimbursement (MAR)	Rationale
8/5/03	90806	\$98.68	125 %	\$123.35	
8/5/03	90889			N/A	Bundled, per Medicare Fee Schedule
8/12/03	90806	\$98.68	125 %	\$123.35	
8/12/03	90889			N/A	Bundled, per Medicare Fee Schedule
9/16/03	90901	\$49.61	125 %	\$62.01 (x2) = \$124.02	Per Medicare Fee Schedule, paid in increments of 30 minutes
9/16/03	90901 –51			N/A	Not a valid modifier, per Medicare Fee Schedule
9/16/03	90889			N/A	Bundled, per Medicare Fee Schedule
Total				\$370.72	Reimbursement Recommended

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to partial reimbursement in the amount of \$370.72. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit \$370.72 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 08th day of April 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc